STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185266	A. BUILDING _____ B. WING _____	09/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN NURSING AND REHABILITATION CENTER	1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701

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F 441	Continued From page 10 2. Review of the facility policy for peri care revealed the facility utilizes the reference resource of Lippincott Standards of Practice regarding peri care of the residents. This reference states that when cleaning the perineal area you are to use a different part of the washcloth each time you wipe downward from front to back. Observation of CNA #1 on 09/10/10 at 9:45am performing peri care for Resident #9 revealed CNA #1 applied gloves and then pulled the resident's curtain. The CNA took the clean warm washcloths to be used to bathe the resident and draped them over the end of the resident's bed. While cleaning the peri area, the CNA wiped from front to back but used the same area of the washcloth over and over again on different areas. Interview with CNA #1 on 09/10/10 at 10:00am revealed that she normally pulls the curtain before putting on gloves. When questioned about draping washcloths over the end of the resident's bed she stated that she should have placed them on a clean surface such as a clean towel on the resident's bedside table. The CNA acknowledged that she should have used a clean area of the washcloth for each downward stroke, wiping from front to back, while cleaning the peri area. She stated that by placing the washcloths on the end of the bed and by reusing the same part of the washcloth on different areas of the peri area she could contaminate the area and infection could be a result of the contamination. Interview with the Education/Training Director, on 09/10/10 at 3:00pm revealed that when asked about what staff are taught regarding peri care	F 441	All Certified Nursing Assistants (CNAs) staff completed return demonstrations on proper peri-care by 9/24/10 that was observed by either the Education Training Director (ETD), Assistant Director of Nursing (ADON), or Unit Nurse Supervisor. 4 **FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED, AS FOLLOWS:** Effective for the next 12 weeks the Dietary Manager will observe meals being served to residents in the dining room twice weekly for three weeks; then once weekly for nine weeks. Any issues observed will be corrected immediately. The results of this monitoring will be documented. In addition, for the next 12 weeks the Education Training Director (ETD), Director of Nursing (DON), Assistant Director of Nursing (ADON), or Unit Nurse Supervisor will monitor trays served to residents in their rooms starting week of 9/27/10 for twice weekly for three weeks; then once weekly for nine weeks to ensure for on-going compliance. Any issues observed will be corrected immediately. The results of this monitoring will be documented.	

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F 441	Continued From page 11 she replied that she would have to check the manual. When asked if she could provide a brief summary of the procedure she stated that she would have to check the policy. A copy of the policy for peri care was requested. Four pages from Lippincott Standards of Practice regarding proper peri care were copied and provided as the facility policy. Observation of CNA #3 during perineal care for Resident #4 revealed the CNA washed their hands, applied gloves, and then pulled the privacy curtain. Washcloths with peri-wash were used for cleaning of the perineal area without folding or turning of the washcloth to prevent contamination and potential for infection. Interview with CNA #3 regarding perineal care training revealed that she had no recollection of training during facility orientation. The CNA stated she was unaware that she had gloves on when she positioned the privacy curtain, and was not aware of the need to wipe and fold/turn the washcloths during perineal care to avoid contamination and potential for infection.	F 441	For the next 12 weeks, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Education Training Director (ETD), or Unit Nursing Supervisor will randomly observe two CNA staff weekly completing peri-care to ensure that it is properly completed. This Plan of Correction for Infection Control for handling of food and peri-care compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality Committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Performance Improvement Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.	

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 9/09/10. The facility was found to not meet the minimal requirements with 42 Code of the Federal regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The findings include: Observation on 09/09/10 at 11:00am revealed hanging decorations attached to ten (10) resident room doors. Resident room doors numbered 18, 20, 22, and 28 were located on the Lincoln Lane Unit. Resident room doors numbered 5, 6, 7, 8, 9, and 11 were located on the Heritage Hall Unit. Interview with the Maintenance Director on 09/09/10 at 11:00am revealed they were unaware of the requirement that these decorations had to be treated for flame retardant. NFPA Standard NFPA 101.2000 Edition 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	1 CORRECTIVE ACTIONTAKEN FOR THOSE RESDIENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE Maintenance Manager corrected all medical equipment that was plugged into power strips in resident rooms # 1, 3, 4, 7, 8, 16, and 17. This was K073 POC continued on Page 1A	9/30/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X [signature] TITLE: Administrator (X6) DATE: 9/30/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 073	K073 POC continued from Page 1	K 073		

corrected by plugging this equipment into wall outlets on 9/10/10.

There were three room air conditioner units in resident rooms # 1, 7, and 16 where the wall outlets were not working properly. Maintenance Manager contacted the facility electrician vendor to look at this and repair these wall outlets. This problem was corrected by 9/23/10 and these air conditioner units are now plugged in wall outlets.

This was checked by Administrator on 9/24/10 and all medical equipment and air conditioners were plugged into wall outlets.

2 IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:

Maintenance Manager completed a 100% audit of all facility resident rooms to ensure that all medical equipment and air conditioners were plugged directly into wall outlets, not power strips. This was completed by 9/10/10 and any identified problems were corrected.

3 MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:

Administrator conducted an in-service for all department managers regarding this issue on 9/13/10. Education Training Coordinator then conducted this in-service with all other facility staff by 9/24/10. This in-service consisted of the following information: all medical equipment, air mattresses, electric beds, nor air conditioner units are to be plugged into power strips. All of these electric items must be plugged into wall outlets.

4 FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED, AS FOLLOWS:

To ensure that this deficient practice does not recur the following monitor has been put into place --- For the next 12 weeks the Maintenance Manager will complete an audit of all resident rooms to ensure that all medical equipment in use is plugged into a wall outlet. Any identified problems will be corrected immediately. Maintenance Manager is responsible for maintaining audit documentation findings and corrections.

This Plan of Correction for Medical Equipment being plugged into wall outlets compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality Committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Performance Improvement Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate

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K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview conducted during the Life Safety Code survey on 09/09/10, it was determined the facility failed to ensure electrical needs were met according to NFPA standards. This standard was cited on the Life Safety Code survey conducted on 01/06/10. The findings include: Observation during the tour of the facility, on 09/09/10 at 12:00 through 12:30pm, revealed seven resident rooms on the Heritage Hall Unit were using multiple outlet power strips. The following observations were made: 1. Resident room #1 revealed Bed-A had a nebulizer plugged into the power strip and Bed-B had the 115 volt air-conditioner plugged into the power strip. 2. Resident room #3 revealed Bed-B had an oxygen concentrator plugged into the power strip. 3. Resident room #4 revealed Bed-B had a nebulizer plugged into a power strip. 4. Resident room #7 revealed Bed-A had a nebulizer and low air loss mattress plugged into a power strip and Bed-B had a 115 volt air-conditioner plugged into the power strip.	K 147	1 **CORRECTIVE ACTIONTAKEN FOR THOSE RESDIENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE** Maintenance Manager treated all items on resident room doors (resident rooms 5, 6, 7, 8, 9, 11, 18, 20, 22, and 28) with a fire retardant chemical and documented this on a log to proof they had been treated. This was completed by 9/30/10. 2 **IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** Maintenance Manager completed a 100% audit to ensure that all items on resident room doors were identified and were treated fire retardant chemicals. This was completed by 9/30/2010. Administrator did rounding through the facility to ensure that Maintenance Manager had identify all resident rooms that had items on their doors in order to make sure all were treated. This was completed on 9/30/2010	9/30/2010

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K 147	Continued From page 2 5. Resident room #8 revealed Bed-B with an oxygen concentrator plugged into a power strip. 6. Resident room #16 revealed a 115 volt air-conditioner plugged into the power strip. 7. Resident room #17 revealed one power strip for beds A and B with two feeding pumps and an oxygen concentrator plugged into the power strip. Interview with the Maintenance Director, on 09/09/10 at 1:00pm, indicated that he understood they could not use power strips for medical equipment. However, he did not know that air-conditioners could not be plugged into the power strips. Reference NFPA 99, Chapter 3 Electrical Systems 3-3.2.1.2 D Minimum Number Of Receptacles The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	3 **MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:** Administrator educated on 9/13/10 the Maintenance Manager, Social Service Director, and Admission Coordinator of the practice of making sure that all resident items that are to hang on resident room doors must be treated with a fire retardant chemical and that Maintenance Manager will maintain documentation of what items was treated and when. Facility Maintenance Manager will be responsible for treatment of all items. In addition, the Social Service Director sent out a letter on 9/17/10 to all resident responsible parties/family members regarding the need to let either Social Service Director or Maintenance Manager know of any item they wanted placed on a resident room door to ensure that it is fire retardant treated by our facility maintenance before hanging it on the door. K147 POC continued on Page 3A	

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K 147	Continued From page 3	K 147	K147 POC continued from Page 3 4 **FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED, AS FOLLOWS:** For the next 12 weeks, Maintenance Manager will complete weekly auditing to ensure that no new items that have not been treated are not hanging on resident room doors. These weekly audits will start for the week of 10/04/10. Maintenance Manager is responsible for maintaining this audit documentation with findings and corrective action taken. This Plan of Correction compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality Committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Performance Improvement Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate	

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